Iowa Department of Public Health

APPLICATION FOR CERTIFICATE OF NEED

Organized Outpatient Health Facility

1. Name of Facility _____

2. Address _____
   Street City County Zip

3. Person responsible for this project _____

   Telephone _____ FAX _____

   E-mail: _____

4. Type of ownership: Proprietary _____ Nonproprietary _____

5. Will the sponsor/owner be the operator? Yes _____ No _____

   If no, give name of operator or management firm: _____

6. Will the facility be leased? Yes _____ No _____

   If yes, to whom?_____

7. Attach a list of the names and addresses of all persons holding a ten (10) percent or more equity in the facility.

8. If the facility is incorporated, attach a list giving the name, address and position of each corporate officer.

9. Name of Administrator, Director or CEO._____

DESCRIPTION OF PROJECT

10. Attach a brief narrative description of the proposed project (i.e. Does this involve constructing, remodeling, purchasing or leasing of a building? What services will be provided?, etc.)

11. Fill out Exhibit 1 to indicate the total square footage of space planned, and divide this into clinical patient treatment and exam area, office, administration, and indirect service areas such as corridors and mechanical space.

    A. Explain your rationale for the space allocated and why you believe it is adequate.

B. Describe your contact with such entities as the fire marshal and city zoning commission for approval of your physical building.

12. For applicable items, indicate anticipated date for:

Land Purchase _____

Architectural Plans - Schematic Finalized _____

Architectural Plans Completed _____

Letting of Contracts _____

Start of Construction _____

Completion of Construction _____

Offering of Services _____

NEED DETERMINATION

13. On an attachment, provide for the proposed service and for relevant ancillary services:

A. Historical utilization statistics for each of the most recent three years, if applicable.

B. Expected utilization statistics for each of the first three (3) years after the proposal is operational (list assumptions used).

14. What do you consider to be the geographic service area for this project?

15. Where are the area residents now receiving these services?
What other providers are located in this geographic area?
What volume of service others are providing?

16. What will be the impact of your proposal on the service volume of other providers? Please explain your assumptions.

17. State any other indicators of community need for this proposal.

18. Please send a form letter to other providers of similar service in the same geographic area, stating your plan and requesting their utilization history. Include with this application a list of people contacted, as well as any responses you have received.

PERSONNEL

19. Attach a list of the medical staff, by specialty, who will supervise the operation of the project. If certain physicians have particularly relevant experience or interests, please elaborate. Which of these physicians will normally be on the premises during operating hours?

20. What arrangements between your program and other health care providers have been made or are being proposed to refer emergencies, share services, and provide backup? Attach a copy of any formal agreements.

21. Specify your forecasted full-time equivalents (FTEs):

Department	Forecasted FTEs
Administrative	_____
Physician	_____
Nursing RN	_____
LPN	_____
Aides/Orderlies	_____
Therapists (specify type)	_____
Other (identify)	_____
TOTAL	_____

22. Describe plans for providing special personnel training needed and experiences to be required of applicants. Address legal limitations of professional practice.

FINANCIAL FEASIBILITY

23. What do you propose to charge for services? What are the charges for similar services from other providers in your area? Please elaborate regarding comparability of service and any cost savings involved (e.g., if physician fee is included in your charge it should be included in area wide charge comparisons).

24. Attach a budget for each of the first three years of operation. Project revenue and expenses, and comment on variable line items that could be cut if revenue does not meet expectations.

25. Indicate the percentages breakdown of total patient revenues for your facility, by source.

Private Pay _____

Medicare _____

Medicaid _____

Wellmark _____

Other private insurance _____

Other (specify) _____

TOTAL _____

26. Provide a description of the liability insurance you propose to carry, along with any other information which substantiates that your project will either be financially viable or will have adequate subsidy to assure reasonable patient charges.

27. Fill out Exhibit 2 to itemize capital costs and anticipated depreciation. If your project does not expect to include depreciation and interest expense reimbursement through Medicare, Medicaid and Blue Cross, please explain briefly how this cost will be recovered (through patient charges, owner's income taxes, etc.)

28. What will be the source of capital funds? Attach a description of asterisked items.

	Estimated Amount
Cash on Hand	_____
Borrowing*	_____
Federal Funds*	_____
State Funds*	_____
Gifts/Contributions*	_____
Lease**	_____
Other (specify)	_____
TOTAL	_____

*For borrowed funds, please attach a letter from the bond consultant or the lender, indicating the probable terms. Also attach an amortization schedule for the life of the loan, showing the

total debt service per year and the portion of each payment that is principal and which part is interest.

**Attach a copy of proposed lease.

29. Attach audited financial statements and notes for each of the most recent years. Attach a balance sheet forecasting after three years of operation.

30. Explain how the proposed project will contribute to meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, handicapped persons and the elderly.

CERTIFICATION

I, the undersigned, certify that:

1) I have read Chapter 135.61-83, Code of Iowa and the Administrative Rules (IAC 641-202 and 203) promulgated pursuant thereto; and

2) I have read this application, including all exhibits and attachments, and the information therein is, to the best of my knowledge and belief, accurate and true.

Signature of Owner of Chairperson, board of Directors	Printed Name
Position or Title	Date

If you wish to designate an official representative to act on your behalf, as addressee for written notifications and to speak for you before the Health Facilities Council, specify below:

Name _____

Address _____

Telephone _____

Email _____

EXHIBIT 1

SQUARE FOOTAGE CHART

Name of Functional Area*	Present Square Feet	Square Feet to be Constructed/ Renovated	Total Square Feet
TOTALS			

*Examples of functional areas (nursing stations, lab, physician's office, lobby, medical records, etc.)

Exhibit 2
Estimated Application of Funds and Estimated Depreciation

Application of Funds		Estimated Amount	Estimated Average Useful Life	Estimated First Year Depreciation
Site Costs:				
Site Acquisition				
Demolition of Existing Structures				
Site Preparation				
Other (Specify)				
Subtotal	$			
Land Improvements (Specify)	$			
Facility Costs:				
General (Construction Shell)				
Heating, Ventilating, A/C				
Plumbing				
Electrical				
Elevator				
Other Fixed Equipment				
Architectural				
Construction Management, Engineering, Testing, Inspection				
Other (Specify)				
Subtotal	$			
Movable Equipment	$			
Financing Costs:				
Underwriters' Discount				
Pricing Discount				
Feasibility, Legal, Printing & Other				
Interest Expense During Construction				
Less Interest Earned During Construction				
Other (Specify)				
Subtotal	$			
Total Project Costs	$			